Legal Medical Record Redefinition in a Multimedia Environment

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As health information expands beyond the traditional paper-based medical record, HIM professionals need to confront the issues related to defining the medical record. The author provides a detailed assessment guide to the redefinition process.

The Washington State Health Information Management Association's (WSHIMA) health information technology committee held several focus group sessions last fall to discuss the professional practice dilemma of redefining the "legal" medical record in light of the ever-increasing movement from a paper-based environment to a multimedia environment. One of the key questions posed at the focus group sessions was:

"As organizations increasingly move towards electronic multimedia environment, and 'health information' expands beyond the confines of the paper-based medical record, what are the key issues that surround the definitional process which we as health information management professionals need to bring to the forefront to provide both leadership and direction within our organizations?"

From these focus group sessions, a practical assessment guide was developed for use as a professional practice tool by HIM professionals as they continue to expand their roles beyond the walls of the paper-based file rooms throughout the healthcare enterprise.

This article takes the reader through an evaluative process using WSHIMA's practical assessment guide as a basis. This evaluative process is designed to assist HIM professionals with some of the more critical issues in redefining the legal medical record.

Historically, the legal medical record definition was straightforward because patient information storage was straightforward. Medical records were stored either on paper or on microfilm. As such, there was no need for formal documentation or definition of the "legal medical record." However, with the advent of various electronic media for patient information and the ongoing deployment of emerging technologies, defining what is truly the "legal medical record" is more complex. HIM professionals need to begin to address development of a formal definition for the legal medical record—one that cuts across all media types that may exist across a given enterprise.

Practical Assessment Guide

The following assessment guide was developed to provide a practical professional tool for HIM professionals as they begin to address this need for redefinition. While the current "rules" used for the paper-based record may be a good starting point when responding to the evaluation questions, an "out-of-the-box" position is highly encouraged. This redefinitional process for the legal medical record is new and uncharted territory. There are no right or wrong responses to the questions posed in this guide. Innovation and creativity in developing responses throughout this assessment will be key in ensuring the best outcome for a healthcare enterprise.

In redefining the legal medical record within a given enterprise, this evaluation process uses a three-tiered approach.

Organizational Preparation

The organizational preparation process level establishes a framework within which the overall redefinitional processes will occur. This first level of preparation is critical for ensuring a solid foundation for the remaining definitional processes.

Global Definitional Assessment

This second tier allows the organization to establish general ground rules and parameters for the legal medical record definition. Such boundaries are necessary to ensure that this evaluative process would effectively meet the needs of the electronic medical record (EMR) movement for one's organization.

Specific Definitional Assessment

This tier includes a more detailed set of evaluative questions. These questions are posed at a level that will assist the organization's drive through the critical issues that need to be addressed as part of the overall redefinitional process.

Organizational Preparation

To begin to evaluate the redefinition of the legal medical record, one should first establish an organizational framework; specifically, the processes that will be needed to properly incorporate interested parties and to ensure an enterprise-wide viewpoint. This organizational framework will also provide the foundation upon which future components of the legal medical record can be added as appropriate. Some critical evaluative questions that should be addressed follow.

Background Research

To begin development of a redefinitional process for the legal medical record, appropriate background research should be conducted. This background research will help establish the initial foundation for the new legal medical record definition.

Evaluative questions should include inquiry into the following:

- *State laws, regulatory definitions, and accreditation requirements regarding various medicolegal issues, including:*
    - *Discoverability?*[1]
    - *Authentication?*[2]
    - *Retention issues?*[3]

The information from this research component would be prerequisite in establishing fundamental ground rules.

- *One's own legal medical record organizational policies, if any*

If such policies currently exist, they should be reviewed and updated in consideration of the current EMR environment.

- *Research of other authoritative/expert references regarding the legal medical record*

While much of this framework will be newly developed, it is good professional practice to identify other authoritative references or professional peers who may be working through similar issues. The more information sharing one does, the better the overall outcome will be.

Executive-level Support

- *Have the proper executive authorities (e.g., medical staff, administration) who will review and approve all legal medical record recommendations and authorize necessary resources been identified?*

This support is crucial not only for this initial redefinitional process, but also for the ongoing support as the electronic environment continues to evolve.

Organizational Structure

- *Has a specific organizational structure, such as a special task force, been established to define and document the legal medical record for the organization?*

Integration of all interested parties is a critical component to ensure ongoing success of the redefinitional process. A multidisciplinary approach is highly recommended.

Task Force Mandates

Once the organizational structure has been established, do its mandates include the following:

- *Integration of the electronic medical record (EMR) vision of the enterprise into the new legal medical record definition?*

This is critical to ensuring consistency and uniformity as the enterprise EMR vision continues to expand into the future.

- *Realignment of roles and responsibilities for existing organizational bodies as it relates to the ongoing evolution of the legal medical record definition (e.g., forms committee)?*

For example, if optical imaging is one of the media sources for the legal medical record, then incorporation of "image-friendly" requirements into existing forms standards would be a new role for the forms committee.

- *Coordination of the necessary interdepartmental, intradepartmental, and enterprise-wide operational processes as emerging technologies are integrated with the evolving legal medical record definition?*

This is one of the more complex evaluative questions. Operational work flows and processes related to the changing definition of the legal medical record should be assessed using an interdisciplinary approach. Such an approach will assist in providing valuable education to those operational areas which may now "own" a component of the legal medical record based on the revised definition. Proper coordination efforts are needed to ensure that the legal medical record can be accessed in an efficient and effective manner by the healthcare enterprise as needed.

- *Have organizational policies been revised in response to operationalization issues identified with the redefinition of the legal medical record?*

Synchronization of policy changes with the redefinition of the legal medical record is imperative to ensuring the ongoing success of the changes needed.

Organizational Impact Analysis

An organizational impact analysis should be conducted to examine both the immediate and long-term costs or savings associated with the operationalization of the new legal medical record, including:

- patient information collection
- patient information access and retrieval
- patient information release
- patient information storage
- patient information security
- patient care
- management and staffing

As the legal medical record definition cuts across multiple media sources, the costs for managing this information to ensure appropriate access and distribution for all business purposes should be assessed. It is important to attain a balance that allows for ease of access for business, legal, and patient care purposes while also ensuring that both the direct and indirect costs associated with managing this information across various media sources is reasonable.

Final Approvals

- *Have final approvals for the organization's new legal medical record definition been received by all key sponsors?*

Certainly the overall success of the institutionalization of the new legal medical record definition cannot be achieved without the final "blessings" of critical leaders within the organization. While needing administrative approval is a given, it is just as critical to ensure that approvals of others who will serve as advocates for the redefinitional implementation efforts are obtained.

Strategic and Tactical Plan Approvals

- *Have strategic and tactical plans for organization-wide implementation of the final, approved legal medical record definition been drafted?*

While the strategic plans should handle many of the higher-level organizational issues (e.g., political positioning), tactical plans will ensure that the operational components (the "how tos") are carefully thought through.

- *Do these plans include a specific communications plan with which to manage organizational expectations?*

Without an effective, well-designed communications plan, implementation efforts of the new legal medical record definition could be potentially hampered or damaged. Management of expectations is a key success factor in the overall redefinitional rollout.

Global Definitional Assessment

To ensure a solid foundation for the legal medical record definition, there should be careful review and consideration regarding the various "boundaries" within which the legal medical record definition should reside. This assessment provides a review of some of these key issues.

Uses and Users

- *Has the definition of both the internal and external uses for the legal medical record been determined, including:*
    - legal?
    - financial?
    - clinical?
    - other?

It is important that any and all media sources defined as a part of the legal medical record can effectively accommodate all existing business requirements across each of these areas.

- *Has identification of both the internal and external **users** of the legal medical record been determined?*

These users may differ depending upon the media type defined as part of the legal medical record. Thus, multiple sets of users by media type may need to be established.

Components

- *Is there a definition of the specific components that will comprise the legal medical record definition, such as:*
    - data?
    - documents?
    - images?
    - other?

In a multimedia environment, each component should be clearly delineated and included in the overall definition of the legal medical record.

Standards

- *Has there been delineation of the standards for the new legal medical record definition, including:*
    - structure?
    - format?
    - organization?

Each of the standard sets for the areas above may vary depending upon the media type. As such, each should be within the overall definitional process of the legal medical record.

Access

- *Have access rights to the new legal medical record components been defined?*

As the legal medical record is defined across more media sources, consideration of additional security measures for each health information component included in the legal medical record will be needed. This is particularly critical given that the EMR will provide much broader access capabilities. The "need to know" must be carefully balanced with protection of patient confidentiality.

Specific Definitional Assessment

Overview

In working through the specific definitional issues for the legal medical record, this third evaluative tier provides guidance when conducting a review of the health information itself. This review level will call for a thorough analysis when making a definitional decision for each health information set presented to the task force.

Current Situational Assessment

- *In assessing each document within the paper-based medical record, does a comparable electronic version of this document exist? If so, which media type should be deemed as a part of the legal medical record?*

Having a clear understanding of where health information exists in duplicate across various multimedia materials is a critical first step in the detailed assessment process. Decisions on which media type for a given set of health information will serve as the legal medical record component need to be made.

- *How should primary, secondary, and tertiary records be handled?* [4]

Handling standards for these different levels of records need to be established for medicolegal purposes. Some health information across each level may be retrieved as part of the legal medical record on an ongoing basis, some may be retrieved on an "as requested" basis, and some will never be retrieved as part of the legal medical record. These decisions need to be made for all health information contained within these three record levels.

- *If you currently retain "shadow" records,*[5] *is there any unique content within them that should be included as a part of the legal medical record?*

"Shadow" records typically contain copies of specific components of the legal medical record. A separate assessment should be conducted to ensure that these records do not contain health information that is not already included within the legal medical record. Appropriate measures should be taken to correct such a situation.

"New" Health Information Considerations

In assessing new EMR information that could potentially be included as part of the legal medical record, nontraditional patient information should now be considered in the redefinitional process.

Evaluative questions for consideration when assessing these new types of health information should include:

- *E-mail:*[7]
    - *How does this information differ from phone/ hallway conversations?*
    - *Should inclusion in the legal medical record be organizationally or physician-driven?*
    - *What kinds of correspondence should be included, if any (e.g., MD to MD; patient to MD; MD to patient)?*

A number of both medicolegal and organizational guidelines surrounding this area need to be established before being incorporated into the legal medical record definition.

- *Clinical protocols/critical pathways/research protocols:*
    - *Would this information be supportive from a medicolegal perspective?*

As this type of health information is increasingly used during the patient's episode of care, further evaluation as to its applicability as part of the legal medical record should be made.

- *MD alerts/reminders/expert system rules:*
    - *Has this information been set up to assist clinicians in rendering decisions for patient diagnostic or therapeutic care?*

This type of clinical resource information is increasingly used in many health information clinical systems and should be carefully scrutinized as to whether it should be incorporated as part of the legal medical record definition.

- *Dynamic data (e.g., IV flow measurements):*
    - *How would this health information be captured and retained over time?*

The complexity in considering ever-changing health information as part of the legal medical record needs to be carefully evaluated.

- *User-specific screen views (e.g., physician-specific views):*
    - *If a given clinician renders a clinical decision based on this information, should these clinical view "snap- shots" be incorporated into the legal medical record's definition?*

Many clinical health information systems allow for customized screen views that give each clinician a unique, individualized set of health information for patient care purposes.

Other patient information for consideration:

- patient inquiry forms (e.g., pre-procedure forms)
- patient intake questionnaires

As this information becomes increasingly automated, it would be prudent to include it in the overall definitional assessment.

EMR Data Set Considerations

In reviewing each EMR data set, the following questions should be considered:

- *Can the EMR patient information be captured as a representative interpretation (e.g., "snapshot") of a given patient's episode of care for medicolegal and other business needs?*

The patient information included in the legal medical record should be able to accurately depict the events that took place during the episode of care.

- *If it has the potential to change over time, which components should be legitimately included as part of the legal medical record (e.g., preliminary versus final results for lab, transcription, EKGs, etc.)?*

This is similar in nature to the dynamic data evaluation area except that the iterative changes are fewer in number.

- *Can the EMR patient information be efficiently and legibly accessed and retrieved?*

The response to this question is critical in the overall evaluation process. Any response that is not in the affirmative will make it difficult and impractical to consider the information for inclusion in the legal medical record.

- *How is EMR information corrected (e.g., lab entries, changes, deletions)?*

The dynamic nature of some health information will need be to carefully evaluated when considering it for inclusion in the legal medical record.

Specific Legal Medical Record Event Capture

Once the various components of the legal medical record are defined, consider how to specifically delineate how and where these defined events will be.

- *Will the events be:*
    - documented (current or late)?
    - collected?
    - stored?
    - updated (current or late)?
    - transferred?
    - displayed?
    - retrieved?

Each of the above information "events" needs to be evaluated across each of the health information components that will be included in the legal medical record definition. This will ensure ongoing integrity of the health information.

Conclusion

At the end of the evaluation process, a clearly defined road map should be in place to allow the health information manager to guide his or her organization down the EMR pathway. The journey is only beginning as health information managers continue to provide leadership and direction in our position as the health information "knowledge" engineers for the EMR.

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Notes

1. Refer to your individual state guidelines as well as the Joint Commission manual, IM Standard 6.1.
2. Joint Commission on Accreditation of Healthcare Organizations. *Comprehensive Accreditation Manual for Hospitals*. Oak Brook Terrace, IL: Joint Commission, 1997, IM Standards 7.1.1 and 7.8.
3. Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, IM Standard 6.1. Also refer to your individual state guidelines.
4. Primary record: The legal business record; what will be retrieved for requestors. Generated at or for the facility (e.g., unit record, referral lab, satellite records). Secondary record: An adjunctive component of the legal business record as defined by facility. Currently maintained in a separate location or database, retrieved on demand or on request (e.g., videotape, preliminary lab, digitized records such as EEGs, fetal monitors, CCU flow sheets). Tertiary record: Correspondence, shadow records.
5. Shadow record: A separate, unofficial record maintained by non-HIM department operational areas of an enterprise. Not typically considered part of the primary or secondary legal records, but more likely a tertiary record (e.g., copies of the primary record, office phone records).

6. Kane, Beverley, and Daniel Z. Sands. "Guidelines for the Clinical Use of Electronic Mail with Patients." *Journal of the American Medical Informatics Association* 5, no. 1 (1998). Also available at http://amia2.amia.org/positio2.htm.

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Article Citation:

Okamoto, Carole. "Legal Medical Record Redefinition in a Multimedia Environment." *Journal of AHIMA* 69, no.9 (1998): 71-76.